Shape of Training review FICM

No.	Question	Comments
1.	Over the next 30 years, how do you think the way patients are cared for will change?	Historically acutely ill patients were traditionally cared for within the hospital environment by trainee doctors. The acutely ill would be intermittently reviewed by consultants, many of whom spent the majority of the clinical time practising their medical specialty or sub-specialty. This approach has led to sub-optimal acute care as acknowledged by both Medical Colleges and the Department of Health. In the future the acutely ill should be rapidly assessed, treated and regularly reassessed by fully trained and qualified medical practitioners. These practitioners will work in large teams and will take on the responsibility for 24/7/365 day care of these patients. Assuring continuity of care will become even more important and training will need to include learning how to provide team-based continuity They will coordinate the care of this group and will invite specialists as and when needed to perform specific tasks and interventions. These practitioners will require a very broad-based training which is therefore likely to be lengthy. Paradoxically the specialists that they will periodically consult may need a much shorter training. The number of these practitioners that will be needed in the next 30 years will increase very significantly. This number is driven by the fact that there will be an increasing number of elderly patients with complex co-morbidities who will have multiple episodes when they destabilise. The interaction between their co-morbidities will be at least as important in determining their acute presentation as their specific conditions. Many of these patients will require prolonged periods of recovery and rehabilitation. Separation between acute care hospitals and more chronic care/rehabilitation facilities will occur. Such models are already available in North America. Medical practitioners with different skill sets, but again with very broad-based training will be required to care for this group of patients who need a prolonged phase of rehabilitation. Specialist and emergency surgery will increasingly be centralised with important consequences for the location of support services including other acute care providers. An increasing number of women doctors will care for patients. Their career choices and patterns of training and working may significantly differ from the previously male dominated medical workforce. In addition more medical practitioners are likely to want to work less than full time and take career breaks.

2.	What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?	Primary care will continue to focus on the treatment of long-term conditions and the prevention of illness. Much of this care can be protocolised and the number of doctors as opposed to trained health care professionals needed to deliver this care should be reviewed. The current aspiration to move more of the medical workforce into general practice should be examined on this basis. As discussed in question 1 acute secondary care will need doctors with a broad-based training. This requirement is due to the mounting complexity, and diagnostic and therapeutic difficulties that the increasing number of elderly patients with multiple co-morbidities will present.
3.	What do you think will be the specific role of general practitioners (GPs) in all of this?	The way in which out of hours and initial emergency care is to be provided to patients in the community needs review. General Practice needs to decide on how much of this acute care they will/can provide and then services configured on this basis. Depending on these decisions the training needs of community based doctors and acute hospital based doctors can be determined. Improved integration of acute care between the community and hospital services is needed and further debate should occur on how this is best provided.
4.	If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors' training (including GP training) change to meet these needs?	In acute care generalists are extremely important, and particularly so in the secondary and tertiary care environment of major hospitals. These generalists will have a very broad medical knowledge, will be the experts in both delivering and coordinating acute care, will be expert diagnosticians, will be comfortable with the considerable diagnostic, therapeutic and prognostic uncertainty that they will face in clinical practice and will be good communicators. The training that they require should reflect these needs. All acute care practitioners should share the same initial stages of training and the current ACCS programme should be expanded to reflect this need. Acute care training should not be regarded as producing a sort of inferior sub-specialist. It is incorrect to assume that they could be trained in a shorter period of time compared to specialist training. To acquire all the skills of the generalist will need a prolonged period of training and it may be possible to train specialists in a shorter period of time due to their more limited scope of practice.

5.	How can the need for clinical academics and researchers be best accommodated within such changes?	Clinical academics are essential for building the evidence base which leads to better patient care. In addition economic constraints, coupled with increasing demand and expectation, will increase the need for high quality research in order to ensure that we deliver the most effective and cost effective solutions for clinical care. This is particularly important for technology-heavy solutions like intensive care, where new technology may add substantial cost to care, but can also make care substantially more cost effective through paradigm shifts in how it is delivered. It is essential that we train a cohort of clinical academics who have the ability to ask the right questions, the skills to answer them, and the clinical involvement to ensure effective implementation of any healthcare improvements that emerge. In practical terms, this will mean that we need to fund research training for clinicians at least at the level supported by the NIHR at present. It is also important that such academic trainees be encouraged, through funding calls, to engage with the highest quality science at every stage of biomedical research – basic biomedical science, translational research, experimental medicine, clinical trials, health service research, and (crucially) implementation research. At an organisational level, rigid time based assessments for completion of training must be rethought, so that academic training careers are not unreasonably prolonged. We also need to ensure that clinical and research training for such individuals is geographically integrated in single centres as much as possible, so that clinical researchers can remain in contact with an ongoing program of research while carrying on with their clinical training. It is also important to recognise that the benefits of new biomedical science (precision medicine, stratified and personalised medicine, and the innovative use of large scale digital patient records) do not pass clinicians by. There needs to be a concerted effort to ensure that these approaches to improving clinical care are embedded in the professional mindsets of all medical students and clinical trainees, including (and perhaps especially) those who do not have aspirations to become career academics. This will ensure that the clinical workforce is able to support clinical research that provides the substrate for evidence based medicine. It is likely that this may increasingly be undertaken in a Comparative Effectiveness Research framework based on everyday care and mined through advances in data storage and handling, rather than just organised as formal clinical trials. Such research active NHS consultants need to become the norm (or at least far more common) in larger hospitals, and should be encouraged in all centres. However, integrating research awareness and enthusiasm into every clinician will have wider benefits in delivering a more informed clinical workforce, who are better able to respond to the needs for increased knowledge development and accelerated knowledge transfer.

6.	How would a more flexible approach to postgraduate training look in relation to:	
6a	Doctors in training as employees?	Hospital based acute care faces major challenges in terms of matching increasing demand against current workforce numbers. The over-reliance on trainees has prevented hospitals from developing satisfactory solutions to this problem. Flexible training implies multiple sampling of various areas of clinical practice at a relatively low level of expertise. These trainees therefore contribute relatively little to the service delivery in these areas and in addition their training needs occupy a significant amount of time. The delivery of acute hospital-based services relies on an outdated model that assumes that somehow service and training needs can always be met with a predominantly trainee based workforce. This is clearly not the case and the only solution to this problem is to move to a full financial separation of training and service delivery needs. In this new model the majority of clinical service is delivered by fully qualified practitioners. Trainees are attached to teams depending on their training requirements and are in some ways supernumerary. However it will remain important for the trainees to feel part of these teams and of the utmost importance for them to deliver actual supervised care as part of their training.
6b	The service and workforce planning?	Tailoring training to workforce planning continues to be a major problem for the National Health Service. We do not believe that flexible training is a complete solution to this problem. Workforce planning in the National Health Service is extremely difficult. One proposed training model envisages a broad-based initial training followed by more specific training tailored to specialty. In theory this would then allow the trainees to tailor the specialty training to the predicted workforce requirements at a time that is closer to their completion of training. We do see an advantage to a general acute care training scheme and in some ways this scheme is already in place in the form of the acute care stem training. We would support an extension of this training to all trainees who wish to be involved in acute hospital care following CCT qualification. However as we have discussed we believe that this period of core training will not equip doctors to take on independent practitioner roles in acute hospital care and further, advanced training will also be needed. We strongly believe, backed by survey and modelling evidence, that a significant expansion in fully qualified Critical Care practitioners will be needed in the next 30 years. These trainees will want training programmes that feature more flexible training and may allow training breaks during which full service delivery (at the defined competency level reached) would be possible.

6c	The outcome of training – the kinds and functions of doctors?	Doctors will be trained to perform specific and pre-defined roles. They will need to continue and revise this training throughout their careers as new medical advances and diseases appear. The purpose of revalidation is to ensure that doctors continue to be capable of performing these roles.
6d	The current postgraduate medical education and training structure itself (including clinical academic structures)?	There is a risk that the increasing requirement for *evidence* of training competency, with a rigid need for the collection of documents and information, deflects trainees and trainers from the real aim of training which is to produce competent, confident and capable independent practitioners. Most training schemes now only operate in a single geographical area. This is clearly convenient and often popular with trainees but may limit the range of training experience available to them. For Academic Intensive Care training the logistic issues for trainers and Deaneries during the early and late part are different. At the early stages, it is very important that trainees are exposed to the widest range of academic training opportunities as possible, and where they make initial progress in this pathway, have the ability to find funding for a PhD as part of a research training fellowship. These requirements demand that local training schemes promote and publicise research training opportunities that are available in their region. This will involve identifying research active clinicians within individual specialties and research opportunities in research groups outside a parent specialty, which may provide individuals and the specialty with new research skills. It is highly desirable that there is an individual within each regional training scheme who takes responsibility for these issues. At later stages of academic training the main focus of Deaneries and training schemes should be to ensure that the remainder of the individual's clinical training is delivered in a way that facilitates their ongoing professional development as researchers, while ensuring that they complete high quality clinical training without needlessly prolonging their training time. It is highly desirable that postdoctoral clinicians who wish to continue to train as clinical academics are allowed the benefit of favourable geography, and allowed to stay in their academic hospital environment, where they can develop both research and funding plans in combination with local collaborators. Regardless of the stage of training, it is essential that these individuals are not burdened by a strictly time-based assessment of their training at this stage. Where clinical training competencies are met, their training time should not be discounted because of an ongoing commitment to research.

7.	How should the way doctors' train and work change in order to meet their patients' needs over the next 30 years?	Acutely ill patients need a 24/7/365 service provided by fully trained and qualified practitioners. Hospital services should focus on this provision which should be their core business. This change will entail a move to shift working for all those delivering such a service. This will require the expansion of trained practitioner numbers and the working in larger teams. Team handovers will become increasingly important. Training will reflect this evolution with trainees receiving real training throughout the 24 hour period rather than the current model of 9 -5 on weekdays. Senior doctors will need to be present in the hospital for a much greater proportion of the 24 hour day, seven days a week. Most acute hospital doctors will work in shifts with a significant nocturnal component. The sustainability of these patterns throughout an increasingly lengthy working career is very uncertain. Agreement on acceptable work patterns with increasing age are needed to avoid the premature loss of experienced acute physicians in the future.
8.	Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?	Yes it does matter. Most patients would want to be treated by a fully qualified and trained practitioner. Patient should support training and need to be aware of the advantages to society of training doctors. In a properly supervised environment being cared for by a trainee should not be a disadvantage. Units with trainee attachment should also be seen as centres of excellent care and should receive trainees partially based on the demonstration of excellence in care delivery. There is a potential tension between the increasing fact that patients will be cared for by a team of qualified practitioners and their need to identify an individual "doctor in charge" particularly in terms of responsibility for quality of care. Patients will need information about the structure of the teams that will care for them and the roles and responsibilities of those that make up the teams.
9.	How should the rise of multi professional teams to provide care affect the way doctors are trained?	Multi-professional teams will help with the training of acute care doctors. Training delivered by experienced and fully qualified practitioners is likely to be of a better quality than that delivered by many inexperienced trainees. In particular the growth of specialist non-medical acute care practitioners is likely to enhance training by greatly improving the ratio of experienced practitioners to trainees.
10.	Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?	In general yes. They are well trained with sufficient clinical experience for their role. Management training is often less satisfactory but can be gained post CCT. Increased team working also allows the mentorship of newly quailed practitioners.

11.	Is the current length and end point of training right?	Currently this is uncertain as the new CCT in Intensive Care Medicine has only just started (August 2012). The current end point of independent practice in the areas covered by the CCT should be maintained.
12.	If training is made more general, how should the meaning of the CCT change and what are the implications for doctors' subsequent CPD?	Training should be designed to allow the trainee to fulfil a pre-defined role in the health care team on qualification. It is not clear from the consultation document as to the aims of "general training". What role will these generally trained doctors perform? In the acute care sector generalists are essential but these are not "half trained" specialists but doctors who have undergone prolonged and in depth training in a number of acute areas in order to optimally care for the very complex acute admissions that are a feature of 21st century medicine. In effect these are specialists in acute care with particular expertise in decision making where both time pressures and considerable diagnostic and prognostic uncertainty exist.
13.	How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?	This would be best achieved by the financial separation of service delivery from training needs. The current service delivery needs tend to hamper training by constraining both the range of posts available and the timing of availability of these posts. Uncoupling of training to service needs would also allow the development of a real competitive market in training and is likely to further increase the quality of training. Tailor-made training programmes would undoubtedly improve training experience although there is some risk of the trainee being perceived as an outsider and not part of the team.
14.	What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?	High quality training programmes should not feature abrupt and unrehearsed changes in responsibilities. Educational supervisors have a key role in ensuring that trainees are capable of moving to the next stage of training. Trainees always need to know how to find support and feel that the offer is genuine. New CCT holders moving into independent practice should be offered formal mentorship and feel able to ask for advice and help.
15.	Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?	See 13.
16.	Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?	See 13. Supervised experience is one of the most effective ways of learning. Trainees therefore must continue to deliver service during their training. Without taking on responsibility for patient care trainees will feel undervalued and will not be able to make a transition to fully independent practice.

17.	What is good in the current system and should not be lost in any changes?	• The UK training system is acknowledged world wide as producing high quality doctors • Many overseas trainees aspire to train in the UK to acquire this training and the qualifications that it entitles. • The majority of the general public believe that their doctors are well trained and are confident in their abilities. • Trainees are already very flexible and quickly adapt to new teams. Very effective clinical teams can often be built very rapidly "from scratch" because of the quality and uniformity of UK training. Many businesses would like to emulate this ability. • Doctors are proud of their abilities and the fact that they feel well trained. • Self-regulation and close involvement of the Royal Colleges and Faculties in standards of training and practice.
18.	Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?	No further comments.